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# Reinventing intention: 'self-harm' and the 'cry for help' in post-war Britain

**Chris Millard [PhD Student]**
Centre for the History of Emotions & School of History, Queen Mary, University of London

## Abstract

**Purpose of review—**To sketch out how contemporary Anglophone literature on self-damaging behaviour negotiates serious conceptual difficulties around intention, and to demonstrate (in the British context) how the large-scale emergence of this type of behaviour is made possible by new forms of psychological provision at district general hospitals.

**Recent findings—**In the past decade there has been increasing public awareness of 'self-harm'. Despite the view that 'self-harm' has always existed, the British roots of the current 'epidemic' can be traced to changes in the organisation of mental healthcare in the post-war period. These changes make possible new understandings of the story behind physical injuries, and allow these readings to be aggregated and projected onto a national, epidemic scale.

**Summary—**The increasing provision of psychiatric expertise in general hospitals makes possible new interpretations of self injury – as psychosocial communication, or affect self-regulation – and creates the phenomenon of 'self-harm' as we understand it today.

### Keywords

Self-harm; parasuicide; attempted suicide; intent; history

## Introduction

That people might act in ways considered harmful to themselves, with a significant level of awareness of the harmful consequences, and yet not be attempting to end their lives, is a long-established idea. Some claim that self-harm has existed as long as humans have existed, finding it in 'Tibetan Tantric Meditation, North American Plains Indian mysticism and the iconography of Christ's Passion' [1] (pp. 2, 11-15). In 1861, the Superintendent of Guy's Hospital noted that 'a large proportion of so-called suicides do not really meditate self-destruction' and are instead attempting 'to procure sympathy or to produce remorse' [2] (p.642). In 1884, the neurologist, George Savage complained of the 'futile' behaviour with regard to suicide, 'found in young girls… [where] there is much more cry than wolf' [3] (pp. 169-70). The complexity of the relationship between self injury and suicide is important. As Erwin Stengel, perhaps the most celebrated analyst of broadly 'self-destructive' behaviour, argued in 1964 '[t]he possibility of such actions and their occasional exploitation has long been known' [4] (p.69).

Over the last eight decades, through the pioneering work of investigators such as Stengel, Karl Menninger, Norman Kreitman and Keith Hawton [5*, 6, 7**, 8, 9*] a broad literature on 'self-harming' behaviours has developed and addresses significant present anxieties (the

Contact Address: 5 Harkness Drive, Canterbury, CT2 7RW. Mobile Telephone: 07926493895 chris.millard@hotmail.co.uk.
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Royal College of Psychiatrists (RCP) has produced four reports about it since 2004 [10-13]). This literature contains a bewildering array of labels: '(deliberate) self-harm' [14-16], 'self-mutilation' [17, 18] and 'self-injury' [19-21] are the most widely known, with 'parasuicide' [7**, 22-25], 'self-poisoning'[26**, 27**], 'attempted suicide' [28**] and even 'pseudocide' [29, 30] all more or less popular at different moments since the end of the Second World War. In this article I show how the model of complex, ambiguous and largely non-suicidal intent promoted in these studies is made possible by post-war hospital reforms, and in the reorganisation, in particular, of Accident and Emergency departments and Mental Observation Wards. I then outline how this model of attempted suicide as a form of social communication is now being overtaken by neurochemical interpretations in terms of affect regulation.

## Complex intent

The new emphasis on the 'appeal function' of the suicide attempt is initiated by Erwin Stengel in 1952 [5*]. By the 1960s, psychiatric and social commentators are talking about an 'epidemic of self-poisoning' [26**, 27**, 31-33], an epidemic understood as a psychopathological communication, a 'distress signal' to the social environment. The central concern of this review is to explain how issues of intent might become visible and problematic in such a way, on such a scale, in the immediate post-war period. There are a number of historical developments that enable consistent psychological scrutiny of patients who present at a general hospital because of a 'physical' injury. As a result of this scrutiny, great emphasis is placed on complex, conflicting and uncertain motivations, rather than solely treating patients through resuscitation or suturing. The extended provision of *psychological expertise* to *district general hospitals* is of critical importance to the emergence of this epidemic, providing the foundation for a new understanding of intention and behaviour.

## General hospitals and psychiatry

Richard Mayou and Hugh Freeman have written informatively on the history of general hospital psychiatry [33, 34* 35-37, 38*, 39], but in general, it is a subject 'that has been neglected by both historians and psychiatrists' [34*] (p. 774). Three dates recur in this narrative in the twentieth century: 1930, when the Mental Treatment Act allows voluntary treatment of mental illness; 1948, when the NHS is inaugurated, complete with responsibility for mental health; and 1959, when all legal obstacles to the treatment of mental illness at general hospitals are removed [40-43]. The association of psychiatry with general hospitals is intimately concerned with 'attempted suicide'. Mayou notes that:

> 'attempted suicide has accounted for a substantial proportion of the cases referred in descriptions of [psychiatric] consultation services published since 1960. However, until the 1950s, hospital cases of attempted suicide were rarely seen by psychiatrists, and indeed, the clinical characteristics were not defined until the publication of a monograph by Stengel & Cook (1958)' [34*] (p.774).

It is through this development that complex intent can emerge consistently. The 1958 monograph attempts to modify the commonsense meaning of the term 'attempted suicide':

> 'The self-injury in most attempted suicides, however genuine, is insufficient to bring about death, and the attempts are made in a setting which makes the intervention of others possible, probable, or even inevitable. There is a *social* element in the pattern of most suicidal attempts. Once we look out for the element we find it without difficulty in most cases' [28**] (p.22).

They 'regard the *appeal character* of the suicidal attempt, which is usually unconscious, as one of its essential features.' [28**] (p.22). In 1965, Neil Kessel describes the term 'attempted suicide' as 'both clinically inappropriate and misleading' [26**] (p.1339). He later recounts '[w]hen we began a systematic investigation in 1961, we thought of our subject as *attempted suicide*' [44] (p.29). However in 1963, he reports that because 'it became generally established that the aim of the majority of those who attempted suicide was not death but to call attention to their distress… [t]he semantic sheet-anchor has been destroyed' [45] (p.987). He names the phenomenon 'self-poisoning'. The lack of a 'semantic sheet-anchor', or what he later calls 'semantic justification' [44] (p.30) indicates that this behaviour defies any classificatory consensus, especially around 'aim' or 'intent'. In McCulloch & Philip's *Suicidal Behaviour* (1972), the 'problem of nomenclature' is explicitly tackled. It is claimed that 'the existing term *attempted suicide* is unsatisfactory, for the reason that many patients so designated are not trying to kill themselves… Such labelling so structures the situation that alternative views of the behaviour become less viable'[46] (p.4). However, '[f]or ease of reading we will use the term *attempted suicide*, with all its reservations, throughout' [46] (p.5), despite one of the authors having proposed a new term 'parasuicide' in the *BJP* in 1969 [22].

This clinical picture emerges in a particular institutional context: mental observation wards in London (Stengel) and Edinburgh (Kessel, McCulloch & Philip). These wards are places to where 'physically injured' patients, arriving at general hospitals, could be psychologically scrutinised more routinely. They exist uneasily between the different therapeutic regimes of psychiatric and general medicine, seen as 'clearing stations' for unmanageable patients as well and those suspected of having a mental disorder [47-49] and are predominantly associated with older Poor Law provision [47, 50, 51]. Mental treatment on these wards is officially discouraged in the mid-1930s (so as not to usurp the role of the mental hospital), but increasingly carried out regardless [52]. When psychological treatment in general hospitals becomes official policy in 1961 many observation wards are recast as 'treatment units' [53, 54].

When suicide is decriminalised in England and Wales in 1961, the Ministry of Health immediately issues a memorandum to all hospitals, asking them to ensure that 'attempted suicides' receive psychiatric assessment. The memorandum claims that '[t]hese cases often come to hospital casualty departments for urgent lifesaving physical treatment… after physical treatment the patient is sometimes discharged without any psychiatric investigation of his condition [which is] of major importance in most cases of attempted suicide' [55**]. 'Physically injured' patients come under more consistent psychological scrutiny; at the same time, this scrutiny focussed, in Michael Shepherd's phrase, upon the 'psychosocial matrix', emphasising the social environment and interpersonal relationships [56, 57**].

The new model of complex intention that underpins the 1960s recasting of 'attempted suicide' is maintained through a system of referral between the distinct therapeutic regimes of accident and psychiatric medicine, practices that still obtain today. The need for psychological treatment of such cases is widely remarked upon around during the late 1950s and early 1960s. For example, it is noted in 1962 that 'the mentally disordered – let us face it – *require very special techniques* and, with the best intentions in the world, cannot be treated entirely like the physically sick.' [58] (p.152) see also [59-61]. Irving Kreeger reports that a 'hazard arises when patients are seen in general hospitals after making suicidal attempts. There is usually considerable pressure for quick discharge … from physicians, who resent their beds being blocked' [62] (p.96). Psychiatrists at King's College Hospital relate that '[t]here is always understandable pressure from physicians and surgeons for these ['attempted suicide'] patients to be transferred or discharged as soon as possible'[63] (p. 179).

W.H. Trethowan's recollections show this transformation from 'attempted suicide' as 'somatic sequelae' to 'psychological cry for help.' He does not recall a single lecture on suicide when a medical student, but does remember that

> 'in the unsuccessful attempts – whether these ultimately proved fatal or not – it was the more immediate after effects which excited the greatest clinical interest – such as the cicatrisation which might follow corrosive poisoning, or dealing with the partial exsanguination and various surgical complications in those who had made more-or-less determined attempts to stab themselves or cut their throats' [64] (pp. 319-320).

However, 'efforts to redefine unsuccessful suicide attempts in different terms' during the 1950s and 1960s resulted in the position that 'attempts at suicide have become such a well-established form of communication between a person in distress and his environment that a satisfactory substitute is almost impossible to find' [64] (p.320). Somatic problems give way to distress-based communication, opening up the possibility for a consistent clinical picture that subordinates the significance of physical harm to psychopathological communication. It is through this shift that 'as every casualty officer well knows, [this phenomenon has] now reached epidemic proportions'[64] (p.320).

The 1960s reading of 'failed suicides' as a cry for help rooted in a 'psychosocial matrix' begins to be overtaken by 'emotional self-regulation' models in the 1980s. The view that this complex intent is part of a strategy of emotional self-regulation still informs current NHS advice which claims that 'the causes [of 'self-harm'] usually stem from unhappy emotions… If somebody is feeling overwhelmed with unhappy emotions, they may find that the physical act of hurting themselves makes them feel better' [65]. This self-regulation is also conceived of in terms of 'tension' [66-69]. As 'emotions' become important in studies of the neurochemistry of 'affect' these explanations shift again. An editorial by David Brent in the *British Medical Journal* in 2011 claims that what he calls '[n]on-suicidal self injury is most commonly used as a mood regulation strategy… thought to relieve negative affect through the release of endogenous opioids' [70] (p.592). Brent declares that the difference between suicide and self-injury can be established on this plane because '[a]lthough non-suicidal self injury and suicide attempts often occur in the same individual and share some common risk factors, their motivations, reinforcers, and neurobiology are distinct' [70] (p. 592) see also (21, 71-78). The idea of 'communication' has not disappeared from the contemporary studies, but now sits rather more negatively associated with 'attention-seeking' behaviour. The idea that non-psychologically trained A&E staff might treat 'self-harmers' as merely attention-seeking time-wasters causes such anxiety to psychological specialists that numerous studies have been designed to reveal the attitudes of 'self-harmers' to service provision [79] or of frontline staff to 'self-harmers'[80].

## Conclusion

Whilst some clinicians now differentiate strongly between 'self-cutting' and 'self-poisoning', downgrading the latter (with the proposed DSM-5 category 'nonsuicidal self-injury' solely involving damage to the *surface* of the body [81] see also [20, 68]) most epidemiological studies do not (the majority of hospital presentations still involve 'self-poisoning' in any case [68, 79]). The prominence of 'poisoning' between the 1950s and the 1970s might be explained through anxieties around GPs overprescribing under the NHS [82, 83], or drug safety post-Thalidomide disaster [84, 85]. The shift in archetypal 'harm behaviour' (mid-1980s in Britain) roughly coincides with a shift in presumed intent, from 'interpersonal communication' to 'emotional self-regulation', perhaps corresponding to the types of psychological scrutiny available, and the fracturing of the 'psychosocial model' of psychiatry.

Whether focussed upon 'cutting' or 'poisoning', the contemporary phenomenon of 'self-harm' is founded upon the consistent provision of psychiatric scrutiny at accident and emergency departments. The transformations from 'cry for help' to 'emotional regulation' to 'opioid production' largely depend upon a clinical picture made visible by the integration of psychiatric and general medicine in the 1950s and 1960s. If 'self-harm' is understood in terms of these efforts to secure consistent psychiatric scrutiny at general hospitals, notions of 'incidence' need to be reconceptualised. It is not *simply* that more people act in certain ways more often, but that the possibility for actions to be understood in a certain way fundamentally depends upon the historical context [86*, 87] – in this case, upon the uneasy combination of two distinctive therapeutic regimes.

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**Key bullet points**

- The current ‘epidemic’ of ‘self-harm’ in Britain can be traced to changes in the organisation of mental healthcare in the post-war period.
- The increasing provision of psychiatric expertise in general hospitals makes possible new interpretations of physical injury.
- These readings are projected onto a national, epidemic scale, undergirding the phenomenon of ‘self-harm’ as we understand it today.